SENATE BILL No. 472

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2; IC 12-15; IC 12-16; IC 34-30-2.

Synopsis: Medicaid matters. Provides that, beginning January 1, 2010, an individual who is receiving monthly assistance payments for the aged, blind, or disabled under the federal Supplemental Security Income (SSI) program or an individual who has a family income that does not exceed 200% of the federal income poverty level (FPL) is eligible for Medicaid. (Under current law, an individual receiving SSI disability payments must also meet the state's: (1) definition of disability; and (2) financial criteria.) Allows the office to determine cost sharing amounts for an individual with a disability whose family income is more than 75% of FPL and terminate the individual's participation in the Medicaid program if the individual does not pay the individual's cost share. Requires the office of the secretary of family and social services to establish an enhanced payment program for hospitals that provide significant medical education or are critical needs hospitals. Authorizes the office of Medicaid policy and planning (office) to collect an assessment on hospitals that may not exceed 5% of the hospital's net revenue from the preceding fiscal year. Creates the Medicaid hospital assessment account. Allows certain individuals to participate in the Indiana check-up plan (plan) without state funding. Allows a nonprofit organization and certain health care insurers and health maintenance organizations to contribute to the health care

(Continued next page)

Effective: Upon passage; July 1, 2009; January 1, 2010.

Miller

January 14, 2009, read first time and referred to Committee on Health and Provider Services.

Digest Continued

account of a plan participant under certain circumstances. Specifies that the minimum amount paid by certain plan participants into the participant's health care account is $60. Adds additional purposes for expenditures from the state hospital care for the indigent fund. Requires the office to: (1) apply to the federal government to change the state's status regarding Medicaid and individuals who participate in SSI; (2) terminate the state's Medicaid spend down program; and (3) increase Medicaid eligibility for individuals with a disability. Repeals a provision allowing for additional payments to specified hospitals. Repeals a provision allowing individuals to obtain health care coverage that is the same as the plan if the plan has reached maximum enrollment using standard underwriting practices. Repeals the hospital care for the indigent program beginning January 1, 2010. Makes technical changes.

Introduced

First Regular Session 116th General Assembly (2009)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2008 Regular Session of the General Assembly.

SENATE BILL No. 472

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-7-2-76, AS AMENDED BY P.L.145-2006, SECTION 48, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 76. (a) "Eligible individual", for purposes of IC 12-10-10, has the meaning set forth in IC 12-10-10-4.

(b) "Eligible individual" has the meaning set forth in IC 12-14-18-1.5 for purposes of the following:

(1) IC 12-10-6.
(2) IC 12-14-2.
(3) IC 12-14-18.
(4) IC 12-14-19.
(5) IC 12-15-2.
(6) IC 12-15-3.
(7) IC 12-16-3.5 **(repealed effective January 1, 2010).**
(8) IC 12-20-5.5.

SECTION 2. IC 12-7-2-104.5, AS AMENDED BY P.L.145-2006,

SECTION 53, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 104.5. "Holocaust victim's settlement payment" has the meaning set forth in IC 12-14-18-1.7 for purposes of the following:

(1) IC 12-10-6.
(2) IC 12-14-2.
(3) IC 12-14-18.
(4) IC 12-14-19.
(5) IC 12-15-2.
(6) IC 12-15-3.
(7) IC 12-16-3.5 **(repealed effective January 1, 2010).**
(8) IC 12-20-5.5.

SECTION 3. IC 12-15-2-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2010]: Sec. 6. (a) ~~Subject to subsection (b),~~ An individual who

~~(1)~~ is receiving monthly assistance payments under the federal Supplemental Security Income program ~~and~~
~~(2) meets the income and resource requirements established by statute or the office unless the state is required to provide medical assistance to the individual under 42 U.S.C. 1396a(f) or under 42 U.S.C. 1382h;~~

is eligible to receive Medicaid.

~~(b) An individual who is receiving monthly disability assistance payments under the federal Supplemental Security Income program or the federal Social Security Disability Insurance program must meet the eligibility requirements specified in IC 12-14-15 unless the state is required to provide medical assistance to the individual under 42 U.S.C. 1382h.~~

~~(c) The office may not apply a spend down requirement to an individual who is eligible for medical assistance under 42 U.S.C. 1382h.~~

(b) An individual:

(1) who is disabled as described in IC 12-14-15-1(2);
(2) whose family income does not exceed two hundred percent (200%) of the federal income poverty level; and
(3) who meets the resource requirements established by statute or the office;

is eligible to receive Medicaid.

(c) The office may determine cost sharing amounts for an individual described in subsection (b) whose family income exceeds seventy-five percent (75%) of the federal income poverty level on a sliding fee scale based on the family income. The cost sharing

amount must include an annual payment by the individual of at least sixty dollars ($60). The payment may be made in monthly installments of at least five dollars ($5).

(d) If an individual's required payment determined under subsection (c) is not made within sixty (60) days after the required payment date, the individual may be terminated from participation in the Medicaid program. The individual must receive written notice before the individual is terminated from the Medicaid program.

(e) After termination from the Medicaid program under subsection (d), the individual may not reapply for Medicaid under this section for twelve (12) months.

SECTION 4. IC 12-15-15-1.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: **Sec. 1.4. The office of the secretary shall establish an enhanced payment program for a hospital licensed under IC 16-21 that is either:**

(1) a hospital that provides significant medical education; or

(2) a critical needs hospital, as determined by the office.

SECTION 5. IC 12-15-15-1.6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 1.6. ~~(a) This section applies only if the office determines, based on information received from the federal Centers for Medicare and Medicaid Services, that payments made under section 1.5(b) STEP FIVE (A), (B), or (C) of this chapter will not be approved for federal financial participation.~~

~~(b) If the office determines that payments made under section 1.5(b) STEP FIVE (A) of this chapter will not be approved for federal financial participation, the office may make alternative payments to payments under section 1.5(b) STEP FIVE (A) of this chapter if:~~

~~(1) the payments for a state fiscal year are made only to a hospital that would have been eligible for a payment for that state fiscal year under section 1.5(b) STEP FIVE (A) of this chapter; and~~

~~(2) the payments for a state fiscal year to each hospital are an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (A) of this chapter for that state fiscal year.~~

~~(c) If the office determines that payments made under section 1.5(b) STEP FIVE (B) of this chapter will not be approved for federal financial participation, the office may make alternative payments to payments under section 1.5(b) STEP FIVE (B) of this chapter if:~~

~~(1) the payments for a state fiscal year are made only to a hospital that would have been eligible for a payment for that state fiscal~~

~~year under section 1.5(b) STEP FIVE (B) of this chapter; and~~

~~(2) the payments for a state fiscal year to each hospital are an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (B) of this chapter for that state fiscal year.~~

~~(d) If the office determines that payments made under section 1.5(b) STEP FIVE (C) of this chapter will not be approved for federal financial participation, the office may make alternative payments to payments under section 1.5(b) STEP FIVE (C) of this chapter if:~~

~~(1) the payments for a state fiscal year are made only to a hospital that would have been eligible for a payment for that state fiscal year under section 1.5(b) STEP FIVE (C) of this chapter; and~~

~~(2) the payments for a state fiscal year to each hospital are an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (C) of this chapter for that state fiscal year.~~

~~(e) If the office determines, based on information received from the federal Centers for Medicare and Medicaid Services, that payments made under subsection (b), (c), or (d) will not be approved for federal financial participation,~~ The office shall use the funds ~~that would have served as the nonfederal share of these payments~~ **under section 1.4 of this chapter** for a state fiscal year to serve as the nonfederal share of a payment program for hospitals to be established by the office. The payment program must distribute payments to hospitals for a state fiscal year based upon a methodology determined by the office to be equitable under the circumstances.

SECTION 6. IC 12-15-15-9, AS AMENDED BY P.L.218-2007, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 9. (a) For purposes of this section and IC 12-16-7.5-4.5 **(repealed effective January 1, 2010),** a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 **(repealed effective January 1, 2010)** for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 **(both repealed effective January 1, 2010)** and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care

occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, and before July 1, 2007, a hospital licensed under IC 16-21-2 that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5 **(repealed effective January 1, 2010)** is entitled to a payment under subsection (c).

(c) ~~Except as provided in section 9.8 of this chapter and~~ Subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5 **(repealed effective January 1, 2010)**, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 **(repealed effective January 1, 2010)** during the state fiscal year; and

(B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 **(repealed effective January 1, 2010)** attributed to the county during the state fiscal year; and

(B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 **(repealed effective January 1, 2010)** attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 **(repealed effective January 1, 2010).**

STEP FOUR: For each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, calculate the hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 **(repealed effective January 1, 2010).** Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 **(repealed effective January 1, 2010)** attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 **(repealed effective January 1, 2010)** attributed to the county

during the state fiscal year.

STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 **(repealed effective January 1, 2010).**

STEP SIX: Determine the sum of all amounts calculated under STEP FIVE for each hospital identified in STEP ONE with respect to each county identified in STEP ONE.

(d) For state fiscal years beginning after June 30, 2007, a hospital that received a payment determined under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2007, shall be paid in an amount equal to the amount determined for the hospital under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2007.

(e) A hospital's payment under subsection (c) or (d) is in the form of a Medicaid supplemental payment. The amount of a hospital's Medicaid supplemental payment is subject to the availability of funding for the non-federal share of the payment under subsection (f). The office shall make the payments under subsection (c) and (d) before December 15 that next succeeds the end of the state fiscal year.

(f) The non-federal share of a payment to a hospital under subsection (c) or (d) is funded from the funds transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 **(repealed effective January 1, 2010).**

(g) The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds of the county transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 **(repealed effective January 1, 2010)** that the total amount of the hospital's payable claims under IC 12-16-7.5 **(repealed effective January 1, 2010)** attributed to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5 **(repealed effective January 1, 2010)** attributed to the county submitted to the division during the state fiscal year.

(h) Any county's funds identified in subsection (g) that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

(i) For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1) **(repealed effective January 1, 2010).**

(j) For purposes of subsection (c):

(1) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 **(repealed effective January 1, 2010)** if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 **(repealed effective January 1, 2010)** includes a payable claim under IC 12-16-7.5 **(repealed effective January 1, 2010)** for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

(k) The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal year.

SECTION 7. IC 12-15-15-9.5, AS AMENDED BY P.L.3-2008, SECTION 93, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 9.5. (a) For purposes of this section and IC 12-16-7.5-4.5 **(repealed effective January 1, 2010),** a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 **(repealed effective January 1, 2010)** for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 **(both repealed effective January 1, 2010)** and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, but before July 1, 2007, a hospital licensed under IC 16-21-2:

(1) that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5; and

(2) whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 **(repealed effective January 1, 2010)** submitted by

the hospital to the division during the state fiscal year;

is entitled to a payment under subsection (c).

(c) Subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5 **(repealed effective January 1, 2010),** that the office determines for the hospital under STEP EIGHT of the following STEPS:

STEP ONE: Identify each county whose transfer of funds to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 **(repealed effective January 1, 2010)** for the state fiscal year was less than the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP TWO: For each county identified in STEP ONE, calculate the difference between the amount of funds of the county transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 **(repealed effective January 1, 2010)** and the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP THREE: Calculate the sum of the amounts calculated for the counties under STEP TWO.

STEP FOUR: Identify each hospital whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP FIVE: Calculate for each hospital identified in STEP FOUR the difference between the hospital's payment under section 9(c) of this chapter and the total amount of the hospital's payable claims under IC 12-16-7.5 **(repealed effective January 1, 2010)** submitted by the hospital to the division during the state fiscal year.

STEP SIX: Calculate the sum of the amounts calculated for each of the hospitals under STEP FIVE.

STEP SEVEN: For each hospital identified in STEP FOUR, calculate the hospital's percentage share of the amount calculated under STEP SIX. Each hospital's percentage share is based on the amount calculated for the hospital under STEP FIVE calculated as a percentage of the sum calculated under STEP SIX.

STEP EIGHT: For each hospital identified in STEP FOUR, multiply the hospital's percentage share calculated under STEP SEVEN by the sum calculated under STEP THREE. The amount

calculated under this STEP for a hospital may not exceed the amount by which the hospital's total payable claims under IC 12-16-7.5 **(repealed effective January 1, 2010)** submitted during the state fiscal year exceeded the amount of the hospital's payment under section 9(c) of this chapter.

(d) For state fiscal years beginning after June 30, 2007, a hospital that received a payment determined under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2007, shall be paid an amount equal to the amount determined for the hospital under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2007.

(e) A hospital's payment under subsection (c) or (d) is in the form of a Medicaid supplemental payment. The amount of the hospital's add-on payment is subject to the availability of funding for the nonfederal share of the payment under subsection (f). The office shall make the payments under subsection (c) or (d) before December 15 that next succeeds the end of the state fiscal year.

(f) The nonfederal share of a payment to a hospital under subsection (c) or (d) is derived from funds transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 **(repealed effective January 1, 2010)** and not expended under section 9 of this chapter.

(g) Except as provided in subsection (h), the office may not make a payment under this section until the payments due under section 9 of this chapter for the state fiscal year have been made.

(h) If a hospital appeals a decision by the office regarding the hospital's payment under section 9 of this chapter, the office may make payments under this section before all payments due under section 9 of this chapter are made if:

(1) a delay in one (1) or more payments under section 9 of this chapter resulted from the appeal; and

(2) the office determines that making payments under this section while the appeal is pending will not unreasonably affect the interests of hospitals eligible for a payment under this section.

(i) Any funds transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 **(repealed effective January 1, 2010)** remaining after payments are made under this section shall be used as provided in IC 12-15-20-2(8).

(j) For purposes of subsection (c):

(1) "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b) **(repealed effective January 1, 2010);**

(2) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the

hospital care for which the payable claim is submitted under IC 12-16-7.5 **(repealed effective January 1, 2010)** if the individual receiving the hospital care had been a Medicaid enrollee; and

(3) a payable hospital claim under IC 12-16-7.5 **(repealed effective January 1, 2010)** includes a payable claim under IC 12-16-7.5 **(repealed effective January 1, 2010)** for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

SECTION 8. IC 12-15-15.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]:

Chapter 15.5. Payment by Hospitals

Sec. 1. (a) As used in this chapter, "hospital"has the meaning set forth in IC 16-18-2-179(b).

(b) The term does not include a hospital owned and operated by the state or by an agency of the United States.

Sec. 2. (a) The office may assess a hospital four percent (4%) of the total annual net revenue of the hospital for the hospital's preceding fiscal year.

(b) The assessment shall be paid to the office in equal monthly amounts on or before the tenth day of each calendar month. The office may withhold Medicaid payments to a hospital that fails to pay an assessment within thirty (30) days after the due date. The amount withheld may not exceed the amount of the assessment due.

Sec. 3. (a) Revenue from the assessments shall be credited to a special account within the state general fund to be called the Medicaid hospital assessment account. Money in the account may be used only for services for which federal financial participation under Medicaid is available to match state funds. Money in the special account remains in the special account for the purposes of the special account and may not revert to any other account in the general fund.

(b) An amount equivalent to the federal financial participation estimated to be received for services financed from the assessments under this section shall be used for the following purposes:

(1) At least seventy percent (70%) of the assessment collected under this section may be used to finance Medicaid services provided by hospitals and hospital reimbursement rate increases.

(2) Not more than thirty percent (30%) of the assessment

collected under this section may be used to fund the following:

(A) Medicaid coverage for the disabled under IC 12-15-2-6.

(B) The Indiana check-up plan under IC 12-15-44.2.

(c) If federal financial participation to match the assessment in this chapter becomes unavailable under federal law, the authority to impose the assessment terminates on the date that the federal statutory, regulatory, or interpretive change takes effect.

SECTION 9. IC 12-15-16-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 3. (a) For purposes of disproportionate share eligibility, a provider's low income utilization rate is the sum of the following, based on the most recent year for which an audited cost report is on file with the office:

(1) A fraction (expressed as a percentage) for which:

(A) the numerator is the sum of:

(i) the total Medicaid patient revenues paid to the provider; plus

(ii) the amount of the cash subsidies received directly from state and local governments, including payments made under the hospital care for the indigent program (IC 12-16-2) (before its repeal) and IC 12-16-2.5 **(repealed effective January 1, 2010)**; and

(B) the denominator is the total amount of the provider's patient revenues paid to the provider, including cash subsidies; and

(2) A fraction (expressed as a percentage) for which:

(A) the numerator is the total amount of the provider's charges for inpatient services that are attributable to care provided to individuals who have no source of payment; and

(B) the denominator is the total amount of charges for inpatient services.

(b) The numerator in subsection (a)(1)(A) does not include contractual allowances and discounts other than for indigent patients not eligible for Medicaid.

SECTION 10. IC 12-15-19-6, AS AMENDED BY P.L.218-2007, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 6. (a) The office is not required to make disproportionate share payments under this chapter from the Medicaid indigent care trust fund established by IC 12-15-20-1 until the fund has received sufficient deposits, including intergovernmental transfers of funds and certifications of expenditures, to permit the office to make the state's share of the required disproportionate share payments.

(b) For state fiscal years beginning after June 30, 2006, if:

(1) sufficient deposits have not been received; or

(2) the statewide Medicaid disproportionate share allocation is insufficient to provide federal financial participation for the entirety of all eligible disproportionate share hospitals' hospital-specific limits;

the office shall reduce disproportionate share payments made under IC 12-15-19-2.1 and Medicaid safety-net payments made in accordance with the Medicaid state plan to eligible institutions using an equitable methodology consistent with subsection (c).

(c) For state fiscal years beginning after June 30, 2006, payments reduced under this section shall, in accordance with the Medicaid state plan, be made:

(1) to best utilize federal matching funds available for hospitals eligible for Medicaid disproportionate share payments under IC 12-15-19-2.1; and

(2) by utilizing a methodology that allocates available funding under this subdivision, and Medicaid supplemental payments as ~~defined~~ **described** in ~~IC 12-15-15-1.5,~~ **IC 12-15-15-1.4,** in a manner that all hospitals eligible for Medicaid disproportionate share payments under IC 12-15-19-2.1 receive payments using a methodology that:

(A) takes into account the situation of the eligible hospitals that have historically qualified for Medicaid disproportionate share payments; and

(B) ensures that payments for eligible hospitals are equitable.

(d) The percentage reduction shall be sufficient to ensure that payments do not exceed the statewide Medicaid disproportionate share allocation or the amounts that can be financed with:

(1) the amount transferred from the hospital care for the indigent trust fund;

(2) other intergovernmental transfers;

(3) certifications of public expenditures; or

(4) any other permissible sources of non-federal match.

SECTION 11. IC 12-15-20-2, AS AMENDED BY P.L.218-2007, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 2.The Medicaid indigent care trust fund is established to pay the non-federal share of the following:

(1) Enhanced disproportionate share payments to providers under IC 12-15-19-1.

(2) Subject to subdivision (8), disproportionate share payments to providers under IC 12-15-19-2.1.

(3) Medicaid payments for pregnant women described in

IC 12-15-2-13 and infants and children described in IC 12-15-2-14.

(4) Municipal disproportionate share payments to providers under IC 12-15-19-8.

(5) Payments to hospitals under IC 12-15-15-9.

(6) Payments to hospitals under IC 12-15-15-9.5.

(7) Payments, funding, and transfers as otherwise provided in clauses (8)(D), (8)(F), and (8)(G).

(8) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund, the following apply:

(A) The entirety of the intergovernmental transfers deposited into the Medicaid indigent care trust fund for state fiscal years ending on or before June 30, 2000, shall be used to fund the state's share of the disproportionate share payments to providers under IC 12-15-19-2.1.

(B) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year ending June 30, 2001, an amount equal to one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998, and ending June 30, 1999, shall be used to fund the state's share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, for the state fiscal year shall be used to fund the state's share of additional Medicaid payments to hospitals licensed under IC 16-21 pursuant to a methodology adopted by the office.

(C) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund, for state fiscal years beginning July 1, 2001, and July 1, 2002, an amount equal to:

(i) one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998; minus

(ii) an amount equal to the amount deposited into the Medicaid indigent care trust fund under IC 12-15-15-9(d) for the state fiscal years beginning July 1, 2001, and July 1, 2002;

shall be used to fund the state's share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, must be used to fund the state's share of additional Medicaid payments to hospitals

licensed under IC 16-21 pursuant to a methodology adopted by the office.

(D) The intergovernmental transfers, which shall include amounts transferred under IC 12-16-7.5-4.5 **(repealed effective January 1, 2010),** deposited into the Medicaid indigent care trust fund and the certifications of public expenditures deemed to be made to the Medicaid indigent care trust fund, for the state fiscal years ending after June 30, 2005, but before July 1, 2007, shall be used, in descending order of priority, as follows:

(i) As provided in clause (B) of STEP THREE of IC 12-16-7.5-4.5(b)(1) **(repealed effective January 1, 2010)** and clause (B) of STEP THREE of IC 12-16-7.5-4.5(b)(2) **(repealed effective January 1, 2010),** to fund the amount to be transferred to the office.

(ii) As provided in clause (C) of STEP THREE of IC 12-16-7.5-4.5(b)(1) **(repealed effective January 1, 2010)** and clause (C) of STEP THREE of IC 12-16-7.5-4.5(b)(2), **(repealed effective January 1, 2010),** to fund the non-federal share of the payments made under IC 12-15-15-9 and IC 12-15-15-9.5.

(iii) To fund the non-federal share of the payments made under IC 12-15-15-1.1, IC 12-15-15-1.3, and IC 12-15-19-8.

(iv) As provided under clause (A) of STEP THREE of IC 12-16-7.5-4.5(b)(1) **(repealed effective January 1, 2010)** and clause (A) of STEP THREE of IC 12-16-7.5-4.5(b)(2) **(repealed effective January 1, 2010),** for the payment to be made under ~~clause (A) of STEP FIVE of IC 12-15-15-1.5(b).~~ **IC 12-15-15-1.4.**

(v) As provided under STEP FOUR of IC 12-16-7.5-4.5(b)(1) **(repealed effective January 1, 2010)** and STEP FOUR of IC 12-16-7.5-4.5(b)(2) **(repealed effective January 1, 2010),** to fund the payments to be made under ~~clause (B) of STEP FIVE of IC 12-15-15-1.5(b).~~ **IC 12-15-15-1.4.**

(vi) To fund, in an order of priority determined by the office to best use the available non-federal share, the programs listed in clause (H).

(E) For state fiscal years ending after June 30, 2007, the total amount of intergovernmental transfers used to fund the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5 shall not exceed the

amount provided in clause (G)(ii).

(F) As provided in clause (D), for the following:

(i) Each state fiscal year ending after June 30, 2003, but before July 1, 2005, an amount equal to the amount calculated under STEP THREE of the following formula shall be transferred to the office:

STEP ONE: Calculate the product of thirty-five million dollars ($35,000,000) multiplied by the federal medical assistance percentage for federal fiscal year 2003.

STEP TWO: Calculate the sum of the amounts, if any, reasonably estimated by the office to be transferred or otherwise made available to the office for the state fiscal year, and the amounts, if any, actually transferred or otherwise made available to the office for the state fiscal year, under arrangements whereby the office and a hospital licensed under IC 16-21-2 agree that an amount transferred or otherwise made available to the office by the hospital or on behalf of the hospital shall be included in the calculation under this STEP.

STEP THREE: Calculate the amount by which the product calculated under STEP ONE exceeds the sum calculated under STEP TWO.

(ii) The state fiscal years ending after June 30, 2005, but before July 1, 2007, an amount equal to thirty million dollars ($30,000,000) shall be transferred to the office.

(G) Subject to IC 12-15-20.7-2(b), for each state fiscal year ending after June 30, 2007, the total amount in the Medicaid indigent care trust fund, including the amount of intergovernmental transfers of funds transferred, and the amounts of certifications of expenditures eligible for federal financial participation deemed to be transferred, to the Medicaid indigent care trust fund, shall be used to fund the following:

(i) Thirty million dollars ($30,000,000) transferred to the office for the Medicaid budget.

(ii) An amount not to exceed the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5.

(iii) An amount not to exceed the non-federal share of payments to hospitals made under IC 12-15-15-1.1 and IC 12-15-15-1.3.

(iv) An amount not to exceed the non-federal share of disproportionate share payments to hospitals under

IC 12-15-19-8.

(v) An amount not to exceed the non-federal share of payments to hospitals under ~~clause (A) of STEP FIVE of IC 12-15-15-1.5(c).~~ **IC 12-15-15-1.4.**

(vi) An amount not to exceed the non-federal share of Medicaid safety-net payments.

~~(vii) An amount not to exceed the non-federal share of payments to hospitals made under clauses (C) or (D) of STEP FIVE of IC 12-15-15-1.5(c).~~

~~(viii) An amount not to exceed the non-federal share of payments to hospitals made under clause (F) of STEP FIVE of IC 12-15-15-1.5(c).~~

~~(ix)~~ **(vii)** An amount not to exceed the non-federal share of disproportionate share payments to hospitals under IC 12-15-19-2.1.

~~(x)~~ **(viii)** If additional funds are available after making payments under items (i) through ~~(ix),~~ **(vii),** to fund other Medicaid supplemental payments for hospitals approved by the office and included in the Medicaid state plan.

(H) For purposes of clause (D)(vi), the office shall fund the following:

(i) An amount equal to the non-federal share of the payments to the hospital that is eligible under this item, for payments made under ~~clause (C) of STEP FIVE of IC 12-15-15-1.5(b)~~ **IC 12-15-15-1.4** under an agreement with the office, Medicaid safety-net payments and any payment made under IC 12-15-19-2.1. The amount of the payments to the hospital under this item shall be equal to one hundred percent (100%) of the hospital's hospital-specific limit for state fiscal year 2005, when the payments are combined with payments made under IC 12-15-15-9, IC 12-15-15-9.5, and ~~clause (B) of STEP FIVE of IC 12-15-15-1.5(b)~~ **IC 12-15-15-1.4** for a state fiscal year. A hospital is eligible under this item if the hospital was eligible for Medicaid disproportionate share hospital payments for the state fiscal year ending June 30, 1998, the hospital received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004, and the hospital merged two (2) hospitals under a single Medicaid provider number, effective January 1, 2004.

(ii) An amount equal to the non-federal share of payments to

hospitals that are eligible under this item, for payments made under ~~clause (C) of STEP FIVE of IC 12-15-15-1.5(b)~~ **IC 12-15-15-1.4** under an agreement with the office, Medicaid safety-net payments, and any payment made under IC 12-15-19-2.1. The amount of payments to each hospital under this item shall be equal to one hundred percent (100%) of the hospital's hospital-specific limit for state fiscal year 2004, when the payments are combined with payments made to the hospital under IC 12-15-15-9, IC 12-15-15-9.5, and ~~clause (B) of STEP FIVE of IC 12-15-15-1.5(b)~~ **IC 12-15-15-1.4** for a state fiscal year. A hospital is eligible under this item if the hospital did not receive a payment under item (i), the hospital has less than sixty thousand (60,000) Medicaid inpatient days annually, the hospital either was eligible for Medicaid disproportionate share hospital payments for the state fiscal year ending June 30, 1998, or the hospital met the office's Medicaid disproportionate share payment criteria based on state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001, and the hospital received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.

(iii) Subject to IC 12-15-19-6, an amount not less than the non-federal share of Medicaid safety-net payments in accordance with the Medicaid state plan.

(iv) An amount not less than the non-federal share of payments made under ~~clause (C) of STEP FIVE of IC 12-15-15-1.5(b)~~ **IC 12-15-15-1.4** under an agreement with the office to a hospital having sixty thousand (60,000) Medicaid inpatient days annually.

(v) An amount not less than the non-federal share of Medicaid disproportionate share payments for hospitals eligible under this item, and made under IC 12-15-19-6 and the approved Medicaid state plan. A hospital is eligible for a payment under this item if the hospital is eligible for payments under IC 12-15-19-2.1.

(vi) If additional funds remain after the payments made under (i) through (v), payments approved by the office and under the Medicaid state plan, to fund the non-federal share of other Medicaid supplemental payments for hospitals.

SECTION 12. IC 12-15-20.7-2, AS AMENDED BY P.L.218-2007,

SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 2. (a) For each state fiscal year ending before July 1, 2005, and subject to section 3 of this chapter, the office shall make the payments identified in this section in the following order:

(1) First, payments under IC 12-15-15-9 and IC 12-15-15-9.5.

(2) Second, payments under ~~clauses (A) and (B) of STEP FIVE of IC 12-15-15-1.5(b).~~ **IC 12-15-15-1.4.**

(3) Third, Medicaid inpatient payments for safety-net hospitals and Medicaid outpatient payments for safety-net hospitals.

(4) Fourth, payments under IC 12-15-15-1.1 and 12-15-15-1.3.

(5) Fifth, payments under IC 12-15-19-8 for municipal disproportionate share hospitals.

(6) Sixth, payments under IC 12-15-19-2.1 for disproportionate share hospitals.

(7) Seventh, payments under clause (C) of STEP FIVE of IC 12-15-15-1.5(b).

(b) For each state fiscal year ending after June 30, 2007, the office shall make the payments for the programs identified in IC 12-15-20-2(8)(G) in the order of priority that best utilizes available non-federal share, Medicaid supplemental payments, and Medicaid disproportionate share payments, and may change the order or priority at any time as necessary for the proper administration of one (1) or more of the payment programs listed in IC 12-15-20-2(8)(G).

SECTION 13. IC 12-15-44.2-4, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 4. (a) The plan must include the following in a manner and to the extent determined by the office:

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Prescription drug coverage.

(4) Emergency room services.

(5) Physician office services.

(6) Diagnostic services.

(7) Outpatient services, including therapy services.

(8) Comprehensive disease management.

(9) Home health services, including case management.

(10) Urgent care center services.

(11) Preventative care services.

(12) Family planning services:

(A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and

(B) not including abortion or abortifacients.

(13) Hospice services.

(14) Substance abuse services.

(b) The plan must do the following:

(1) Offer coverage for dental and vision services to an individual who participates in the plan.

(2) Pay at least fifty percent (50%) of the premium cost of dental and vision services coverage described in subdivision (1) **for an individual who participates in the plan under section 9(a) of this chapter.**

(c) An individual who receives the dental or vision coverage offered under subsection (b) shall pay an amount determined by the office for the coverage. The office shall limit the payment to not more than five percent (5%) of the individual's annual household income. The payment required under this subsection is in addition to the payment required under section 11(b)(2) of this chapter for coverage under the plan.

(d) Vision services offered by the plan must include services provided by an optometrist.

(e) The plan must comply with any coverage requirements that apply to an accident and sickness insurance policy issued in Indiana.

(f) The plan may not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

SECTION 14. IC 12-15-44.2-5, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 5. (a) The office shall provide to an individual who participates in the plan a list of health care services that qualify as preventative care services for the age, gender, and preexisting conditions of the individual. The office shall consult with the federal Centers for Disease Control and Prevention for a list of recommended preventative care services.

(b) The plan shall, at no cost to the individual, provide payment for not more than five hundred dollars ($500) of qualifying preventative care services per year for an individual who participates in the plan **under section 9(a) of this chapter.** Any additional preventative care services covered under the plan and received by the individual during the year are subject to the deductible and payment requirements of the plan.

SECTION 15. IC 12-15-44.2-9, AS ADDED BY P.L.3-2008,

SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 9. (a) **Except as provided in subsection (b),** an individual is eligible for participation in the plan if the individual meets the following requirements:

(1) The individual is at least eighteen (18) years of age and less than sixty-five (65) years of age.

(2) The individual is a United States citizen and has been a resident of Indiana for at least twelve (12) months.

(3) The individual has an annual household income of not more than two hundred percent (200%) of the federal income poverty level.

(4) The individual is not eligible for health insurance coverage through the individual's employer.

(5) The individual has not had health insurance coverage for at least six (6) months.

(b) An individual who:

(1) meets the requirements of subsection (a) but is not enrolled because the plan has reached maximum enrollment; or

(2) meets all of the requirements in subsection (a) except for subsection (a)(3);

is eligible to participate in the plan. However, the state does not provide funding for health insurance coverage provided under the plan to an individual who is described in this subsection.

~~(b)~~ **(c)** The following individuals are not eligible for the plan:

(1) An individual who participates in the federal Medicare program (42 U.S.C. 1395 et seq.).

(2) A pregnant woman for purposes of pregnancy related services.

(3) An individual who is eligible for the Medicaid program as a disabled person.

~~(c)~~ **(d)** The eligibility requirements specified in subsection (a) are subject to approval for federal financial participation by the United States Department of Health and Human Services.

SECTION 16. IC 12-15-44.2-10, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 10. (a) An individual who participates in the plan must have a health care account to which payments may be made for the individual's participation in the plan only by the following:

(1) The individual.

(2) An employer.

(3) The state.

(4) A nonprofit organization if the nonprofit organization:

(A) is not affiliated with a health care plan; and

(B) does not contribute more than fifty percent (50%) of the individual's required payment to the individual's health care account.

(5) An insurer or a health maintenance organization under a contract with the office to provide health insurance coverage under the plan if the payment:

(A) is to provide a health incentive to the individual; and

(B) does not result in the account balance exceeding one thousand one hundred dollars ($1,100).

(b) The minimum funding amount for a health care account is the amount required under section 11 of this chapter.

(c) An individual's health care account must be used to pay the individual's deductible for health care services under the plan.

(d) An individual may make payments to the individual's health care account as follows:

(1) An employer withholding or causing to be withheld from an employee's wages or salary, after taxes are deducted from the wages or salary, the individual's contribution under this chapter and distributed equally throughout the calendar year.

(2) Submission of the individual's contribution under this chapter to the office to deposit in the individual's health care account in a manner prescribed by the office.

(3) Another method determined by the office.

(e) An employer may make, from funds not payable by the employer to the employee, not more than fifty percent (50%) of an individual's required payment to the individual's health care account.

(f) An insurer or a health maintenance organization may offer a reward under a health incentive program administered by the insurer or health maintenance organization to a participant if the reward is disseminated in one (1) of the following manners:

(1) The reward is deposited into the individual's health care account.

(2) If the individual's health care account is fully funded, the reward may be provided directly to the participant.

(g) A person that makes a contribution to an individual's health care account under subsection (a) shall ensure that the person has not induced or required the participant to receive a health care service from a specific health care provider or facility.

SECTION 17. IC 12-15-44.2-11, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 11. (a) An individual's participation in the plan

does not begin until an initial payment is made for the individual's participation in the plan. A required payment to the plan for the individual's participation may not exceed one-twelfth (1/12) of the annual payment required under subsection (b).

(b) To participate in the plan, an individual shall do the following:

(1) Apply for the plan on a form prescribed by the office. The office may develop and allow a joint application for a household.

(2) If the individual is approved by the office **under section 9(a) of this chapter** to participate in the plan, contribute to the individual's health care account the lesser of the following:

(A) One thousand one hundred dollars ($1,100) per year, less any amounts paid by the individual under the:

(i) Medicaid program under IC 12-15;

(ii) children's health insurance program under IC 12-17.6; and

(iii) Medicare program (42 U.S.C. 1395 et seq.);

as determined by the office.

(B) Not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid by the individual under the Medicaid program under IC 12-15, the children's health insurance program under IC 12-17.6, and the Medicare program (42 U.S.C. 1395 et seq.) as determined by the office:

(i) Two percent (2%) of the individual's annual household income per year if the individual has an annual household income of not more than one hundred percent (100%) of the federal income poverty level.

(ii) Three percent (3%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred percent (100%) and not more than one hundred twenty-five percent (125%) of the federal income poverty level.

(iii) Four percent (4%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent (125%) and not more than one hundred fifty percent (150%) of the federal income poverty level.

(iv) Five percent (5%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred fifty percent (150%) and not more than two hundred percent (200%) of the federal income poverty level.

However, the amount contributed under this subdivision must be at least sixty dollars ($60) per year. The office may allow the contribution to be made in a monthly installment payment of at least five dollars ($5).

(3) If the individual is approved by the office under section 9(b) of this chapter to participate in the plan, contribute to the individual's health care account:

(A) one thousand one hundred dollars ($1,100); and

(B) any other costs associated with the individual's participation in the plan.

(c) The state shall contribute the difference to the individual's account if the individual's payment required under subsection (b)(2) is less than one thousand one hundred dollars ($1,100).

(d) If an individual's required payment to the plan is not made within sixty (60) days after the required payment date, the individual may be terminated from participation in the plan. The individual must receive written notice before the individual is terminated from the plan.

(e) After termination from the plan under subsection (d), the individual may not reapply to participate in the plan for twelve (12) months.

SECTION 18. IC 12-15-44.2-14, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 14. (a) An insurer or health maintenance organization that contracts with the office to provide health insurance coverage, dental coverage, or vision coverage to an individual that participates in the plan:

(1) is responsible for the claim processing for the coverage;

(2) shall reimburse providers at a reimbursement rate of:

(A) not less than the federal Medicare reimbursement rate for the service provided; or

(B) at a rate of one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate; ~~and~~

(3) may not deny coverage to an eligible individual who has been approved by the office to participate in the plan, unless the individual has met the coverage limitations described in section 6 of this chapter; **and**

(4) may not distribute information or materials related to a specific health care provider or facility to an eligible individual or a participant.

(b) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan

must incorporate cultural competency standards established by the office. The standards must include standards for non-English speaking, minority, and disabled populations.

SECTION 19. IC 12-15-44.2-16, AS ADDED BY P.L.3-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 16. (a) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan or an affiliate of an insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan shall offer to provide the same health insurance coverage to an individual who:

(1) has not had health insurance coverage during the previous six (6) months; and

(2) does not meet the eligibility requirements specified in section 9 of this chapter for participation in the plan.

~~(b) An insurer, a health maintenance organization, or an affiliate described in subsection (a) may apply to health insurance coverage offered under subsection (a) the insurer's, health maintenance organization's, or affiliate's standard individual or small group insurance underwriting and rating practices.~~

~~(c)~~ **(b)** The state does not provide funding for health insurance coverage received under this section.

SECTION 20. IC 12-16-7.5-4.5, AS AMENDED BY P.L.146-2008, SECTION 388, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 4.5. (a) Not later than October 31 following the end of each state fiscal year, the division shall:

(1) calculate for each county the total amount of payable claims submitted to the division during the state fiscal year attributed to:

(A) patients who were residents of the county; and

(B) patients:

(i) who were not residents of Indiana;

(ii) whose state of residence could not be determined by the division; and

(iii) who were residents of Indiana but whose county of residence in Indiana could not be determined by the division;

and whose medical condition that necessitated the care or service occurred in the county;

(2) notify each county of the amount of payable claims attributed to the county under the calculation made under subdivision (1); and

(3) with respect to payable claims attributed to a county under

subdivision (1):

(A) calculate the total amount of payable claims submitted during the state fiscal year for:

(i) each hospital;

(ii) each physician; and

(iii) each transportation provider; and

(B) determine the amount of each payable claim for each hospital, physician, and transportation provider listed in clause (A).

(b) For the state fiscal years beginning after June 30, 2005, but before July 1, 2007, and before November 1 following the end of a state fiscal year, the division shall allocate the funds transferred from a county's hospital care for the indigent fund to the state hospital care for the indigent fund under IC 12-16-14 during or for the following state fiscal years:

(1) For the state fiscal year ending June 30, 2006, as required under the following STEPS:

STEP ONE: Determine the total amount of funds transferred from all counties' hospital care for the indigent funds by the counties to the state hospital care for the indigent fund under IC 12-16-14 during or for the state fiscal year.

STEP TWO: Of the total amount of payable claims submitted to the division during the state fiscal year from all counties under subsection (a), determine the amount that is the lesser of:

(A) the amount of total physician payable claims and total transportation provider payable claims; or

(B) three million dollars ($3,000,000).

The amount determined under this STEP shall be used by the division to make payments under section 5 of this chapter.

STEP THREE: Transfer an amount equal to the sum of:

(A) the non-federal share of the payments made under clause (A) of STEP FIVE of IC 12-15-15-1.5(b);

(B) the amount transferred under IC 12-15-20-2(8)(F); and

(C) the non-federal share of the payments made under IC 12-15-15-9 and IC 12-15-15-9.5;

to the Medicaid indigent care trust fund for funding the transfer to the office and the non-federal share of the payments identified in this STEP.

STEP FOUR: Transfer an amount equal to sixty-one million dollars ($61,000,000) less the sum of:

(A) the amount determined in STEP TWO; and

(B) the amount transferred under STEP THREE;

to the Medicaid indigent care trust fund for funding the non-federal share of payments under ~~clause (B) of STEP FIVE of IC 12-15-15-1.5(b).~~ **IC 12-15-15-1.4.**

STEP FIVE: Transfer to the Medicaid indigent care trust fund for the programs referenced at IC 12-15-20-2(8)(D)(vi) and funded in accordance with IC 12-15-20-2(8)(H) the amount determined under STEP ONE, less the sum of the amount:

(A) determined in STEP TWO;

(B) transferred in STEP THREE; and

(C) transferred in STEP FOUR.

(2) For the state fiscal year ending June 30, 2007, as required under the following steps:

STEP ONE: Determine the total amount of funds transferred from all counties' hospital care for the indigent funds by the counties to the state hospital care for the indigent fund under IC 12-16-14 during or for the state fiscal year.

STEP TWO: Of the total amount of payable claims submitted to the division during the state fiscal year from all counties under subsection (a), determine the amount that is the lesser of:

(A) the amount of total physician payable claims and total transportation provider payable claims; or

(B) three million dollars ($3,000,000).

The amount determined under this STEP shall be used by the division for making payments under section 5 of this chapter or for the non-federal share of Medicaid payments for physicians and transportation providers, as determined by the office.

STEP THREE: Transfer an amount equal to the sum of:

(A) the non-federal share of five million dollars ($5,000,000) for the payment made under ~~clause (A) of STEP FIVE of IC 12-15-15-1.5(b),~~ **IC 12-15-15-1.4;**

(B) the amount transferred under IC 12-15-20-2(8)(F); and

(C) the non-federal share of the payments made under IC 12-15-15-9 and IC 12-15-15-9.5;

to the Medicaid indigent care trust fund for funding the transfer to the office and the non-federal share of the payments identified in this STEP.

STEP FOUR: Transfer an amount equal to the amount determined under STEP ONE less the sum of:

(A) the amount determined in STEP TWO; and

(B) the amount transferred under STEP THREE;

to the Medicaid indigent care trust fund for funding the non-federal share of payments under ~~clause (B) of STEP FIVE of IC 12-15-15-1.5(b).~~ **IC 12-15-15-1.4.**

(c) For the state fiscal years beginning after June 30, 2007, before November 1 following the end of the state fiscal year, the division shall allocate the funds transferred to the state hospital care for the indigent fund for the state fiscal year as required under the following STEPS:

STEP ONE: Determine the total amount of funds transferred to the state hospital care for the indigent fund for the state fiscal year.

STEP TWO: Determine the amount specified in STEP THREE.

STEP THREE: The amount to be used under STEP TWO is three million dollars ($3,000,000).

STEP FOUR: Transfer to the Medicaid indigent care trust fund for purposes of IC 12-15-20-2(8)(G) an amount equal to the amount calculated under STEP ONE, minus an amount equal to the amount specified under STEP THREE.

STEP FIVE: The division shall retain an amount equal to the amount remaining in the state hospital care for the indigent fund after the transfer in STEP FOUR for purposes of making payments under section 5 of this chapter or for the non-federal share of Medicaid payments for physicians and transportation providers, as determined by the office.

(d) The costs of administering the hospital care for the indigent program, including the processing of claims, shall be paid from the funds transferred to the state hospital care for the indigent fund.

SECTION 21. IC 12-16-14-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 8. The division shall administer the state hospital care for the indigent fund and shall use the money currently in the fund **for the following purposes:**

(1) To defray the expenses and obligations incurred by the division for hospital care for the indigent.

(2) For coverage of childless adults.

(3) For the administration of state-operated facilities.

The money in the fund is hereby appropriated.

SECTION 22. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 2009]: IC 12-15-15-1.5; IC 12-15-44.2-15.

SECTION 23. THE FOLLOWING ARE REPEALED [EFFECTIVE JANUARY 1, 2010]: IC 12-16-2.5; IC 12-16-3.5; IC 12-16-4.5; IC 12-16-5.5; IC 12-16-6.5; IC 12-16-7.5; IC 12-16-9.5; IC 12-16-10.5; IC 12-16-11.5; IC 12-16-13.5; IC 12-16-16.5; IC 12-16-17;

IC 34-30-2-45.2; IC 34-30-2-45.5; IC 34-30-2-45.7; IC 34-30-2-45.9.

SECTION 24. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) The office shall apply to the United States Department of Health and Human Services for an amendment to the state Medicaid plan or a demonstration waiver to do the following:

(1) Change the state's status from a 209b status regarding Medicaid eligibility for individuals who participate in the federal Supplemental Security Income (SSI) program to a 1634 status that automatically extends Medicaid eligibility to SSI recipients.

(2) Terminate the state's Medicaid spend down program and in the alternative, increase the eligibility percentage for an individual with a disability to two hundred percent (200%) of the federal income poverty level with the authority to require cost sharing as specified in IC 12-15-2-6, as amended by this act.

(c) The office may not implement the state plan amendment or demonstration waiver until the office files an affidavit with the governor attesting that the state plan amendment or demonstration waiver applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the state plan amendment or demonstration waiver is approved.

(d) If the office receives approval to the state plan amendment or demonstration waiver applied for under this SECTION from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (c), the office shall implement the state plan amendment or demonstration waiver not more than sixty (60) days after the governor receives the affidavit.

(e) The office may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(f) This SECTION expires December 31, 2014.

SECTION 25. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "commission" refers to the select joint commission on Medicaid oversight established by IC 2-5-26-3.**

(b) As used in this SECTION, "secretary" refers to the secretary of family and social services.

(c) Not later than September 1, 2009, the secretary shall report to the commission on the status of the following:

(1) The disproportionate share hospital payment system and any legislative changes needed for this system.

(2) The establishment of the enhanced payment group established by IC 12-15-15-1.4, as added by this act.

(3) The readiness for the repeal under this act on January 1, 2010, of the hospital care for the indigent program.

(d) This SECTION expires December 31, 2009.

SECTION 26. **An emergency is declared for this act.**